Child Fatalities, 2006

Statistics, Analyses, and Recommendations

August 2007

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Report Summary

This is the third annual report of trends, findings, and recommendations about fatalities of children who had contact with the Child and Family Services Agency (CFSA) at any time in the past four years (2001-2006). The term "contact" includes (1) current, active cases; (2) cases active in the past but now closed; and (3) reports to CFSA's 24-hour child abuse/neglect hotline that we investigated and determined to be unfounded. (The report was made maliciously or in bad faith, or it had no basis in fact.)

Overall Findings

CFSA had contact with 58 (41%) of the 142 District children who died in 2006.

1: CAUSE OF DEATH

For the second straight year, most children died of natural causes, followed by gunshot homicide.

Natural	28 (48%)
Gunshot homicide	17 (29%)
Accident	5 (09%)
Undetermined/unknown	8 (14%)

2006: No deaths from child abuse

2: CHILD WELFARE CASE STATUS

CFSA's only contact with half the decedents was one or more unfounded child abuse/neglect investigations.

Unfounded investigation(s)	29 (50%)
Closed case	15 (26%)
Active case	14 (24%)

3: AGE OF DECEDENTS

Fully 92% of these children were either younger than age 2 or older than age 12.

<24 months	25 (43%)
2-6 years	2 (03%)
7-12 years	4 (07%)
13-16 years	8 (14%)
17+ years	19 (33%)

Youngest children most at risk of death from natural causes—oldest most at risk of gunshot homicide

4: GENDER OF DECEDENTS

Males were far more at risk. Ratio of male to female decedents was 2.4:1.

Male	41 (71%)
Female	17 (29%)

In-Depth Analyses

- **Children under age 2 had the highest number of fatalities of any single age category** (25 of 58 or 43%). Eighteen died of natural causes. The Medical Examiner could not determine a cause of death for seven.
- **A high number of youth (age 13 and older) died from natural causes**—9 (16%) in 2006 compared to six (10%) in 2004 and three (6%) in 2005.
- **For the third straight year, violent homicide was the leading cause of death for male youth known to CFSA.** Of the 36 District children who died as a result of homicide in 2006, CFSA had contact with 17 (47%) at some point from 2001 through 2006. All the 2006 homicides resulted from gunshots and involved African-American youth ages 14 to 22, including 16 males (94%) and one female.
- **Three of the five accidental deaths in 2006 resulted from vehicles striking children**.
- Of the 58 children with previous CFSA contact who died in 2006, and for whom CFSA knows the location of death, **Wards 5 and 8 had the highest number of child fatalities**: 12 in Ward 5 and 11 in Ward 8. **Eleven (69%) of the 17 child homicides, all by gunshots, took place in Wards 6, 7, or 8. Nine (56%) took place near locations the District has identified as crime hot spots or crime emergency focus areas**.

Background and Methodology

This is the third annual report of trends, findings, and recommendations about fatalities of children who had contact with the District of Columbia's Child and Family Services Agency (CFSA) at any time in the past four years. It is a vehicle for assisting CFSA in improving case practice, correcting deficiencies, strengthening child protective performance, and identifying systemic factors that require citywide attention—all with the goal of reducing preventable child deaths. The report also informs the public of CFSA efforts to ensure the safety of children in District custody. Unless otherwise noted, 2006 fatality data are as of August 31, 2007.

In 1993, the District of Columbia initiated a review of all child fatalities that occur within the city. As a result of the Modified Final Order in the *LaShawn* lawsuit and the Mayor's Order 98-67, the process seeks to identify ways to improve services and supports to families and reduce preventable child fatalities.

The District has a two-tiered process for reviewing child fatalities.

- At the macro level, the citywide Child Fatality Review Committee (CFRC) identifies broad systemic issues that influence child fatalities. Its multidisciplinary review team is composed of representatives from public and private agencies working in education, health and mental health, human services, jurisprudence, law enforcement, and public safety and from the community. The CFRC issues an annual report of citywide statistics and recommendations.

- At the micro level, District child-serving agencies conduct internal reviews of deaths of children known to them. CFSA's Internal Child Fatality Review Team includes agency employees from several programs and functions and representatives from the CFRC; Center for the Study of Social Policy (CSSP, the court-appointed monitor under the *LaShawn* lawsuit); and the community.

Overview of CFSA Child Fatality Review Process

CFSA internally reviews all deaths where we had contact with the child or family within the past four years. The term "contact" includes (1) current, active cases; (2) cases active in the past but now closed; and (3) reports to CFSA's 24-hour abuse/neglect hotline that we investigated and determined to be unfounded (i.e., the report was made maliciously, in bad faith, or had no basis in fact).

When the hotline receives a report of a child death known or suspected to be the result of abuse or neglect, a CFSA investigator responds. The investigator assesses the safety, health, and well

being of children remaining in the care of the decedent's parents or caregivers and evaluates circumstances surrounding the child's death.[1]
CFSA's Quality Improvement Administration (QIA) convenes a Child Fatality Critical Event Meeting within 24 hours of notice of a child fatality[2]. Goals are to explore circumstances surrounding the child's death, assess the level of risk to other children in the home, identify the family's immediate needs, and recommend next steps in the investigation. Participants include representatives from relevant CFSA program areas and the Office of the Attorney General.

If CFSA has current involvement or had contact with the child/family within the previous four years, QIA prepares a child fatality report within 45 days of notification of the child's death[3]. It is based on comprehensive review of information related to the decedent and family from the child welfare investigation or case. Sources include the case record (hard copy and electronic data in FACES, CFSA's automated case management system); the Automated Client Eligibility Determination System (ACEDS)[4]; and interviews with current and past social workers.

QIA then conducts an Internal Child Fatality Review to:

- Determine circumstances surrounding the child's death.
- Identify CFSA's level of involvement with the child/family.
- Assess the quantity and quality of service provision.

A multidisciplinary review panel of representatives from CFSA (Training, Clinical Practice, Program Operations, Quality Assurance, and Legal), and external stakeholders (CSSP, CFRC, and community) makes recommendations that identify issues and immediate actions and long-term strategies for improving case practice and enhancing protection of children.

CFSA's Child Fatality Review Unit then categorizes recommendations from Internal Child Fatality Reviews into the areas of Case Practice, Policy, Training, and Other; tracks CFSA progress in implementing the recommendations; and compiles recommendations in a quarterly report. The Unit forwards this summary report to CFSA senior and middle managers and the CFRC.

Process Improvements in 2006

CFSA eliminated a backlog of child fatality reviews from 2005, and used expert technical assistance to focus and improve the Internal Child Fatality Review process.

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[1]The CFRC also notifies CFSA of child fatalities. Through research into other District agency records and the list of citywide fatalities from Vital Statistics, the CFRC learns about all child fatalities, including some not reported to the CFSA hotline. Sometimes, the CFRC reports these several months after the fact, due to the time lag in receiving information from Vital Statistics.

[2] CFSA does not hold Critical Event meetings in those instances in which we received delayed notification of the fatality.

[3] When CFSA does not conduct an internal review within 45 days of notification of the death, the fatality enters a backlog status.

[4] ACEDS is the District of Columbia's automated process for determining eligibility and certifying individuals to receive Temporary Assistance to Needy Families (TANF), food stamps, and other public assistance benefits.

In January 2006, CFSA had a backlog of 30 fatalities from 2005 that we had not yet reviewed.[5] In 2006, an additional 58 children known to CFSA within the past four years died. We reviewed all 88 fatalities (30 from 2005 and 58 from 2006), eliminating the backlog and becoming current in reviewing new fatalities. The Child Fatality Review Unit is now on target in holding fatality reviews within 45 days of notification.

In March 2006, CFSA convened a workgroup that included representatives of our Internal Review Committee, the CFRC, and CSSP to receive technical assistance from the National Resource Center for Child Protective Services. The parties agreed to four objectives to improve the internal fatality review process:

- Enhance participation from external stakeholders.
- Develop short- and long-term strategies to ensure that fatality reviews occur in a timely manner.
- Ensure Internal Review meetings focus on practice, policy, training, and CFSA systemic issues.
- Modify and/or restructure child fatality reports to focus on specific questions about services, reasonable efforts, case practice, policy, and training.

CFSA implemented these objectives by:

- Notifying external stakeholders in advance of upcoming internal reviews.
- Holding internal reviews on a standard day and time (fourth Thursday of every month at 12:30 p.m.).
- Restructuring child fatality reports to focus on case practice, training, and policy issues and providing copies of the reports to participants at least three days in advance of internal reviews.
- Providing all participants with questions to consider in advance and to focus the discussion during internal reviews (see box).

1. Did CFSA take every action and make every reasonable effort to ensure the safety of the child and other children in the household?

2. Does this child fatality reveal any practice, training, or policy issues that we need to resolve? What are other systemic issues such as supervision, staffing, access to records etc.?

3. Knowing what we know now, what would we do differently?

4. What interagency issues should we present to City-Wide Child Fatality Review Committee?

5. Did parental or familial behavior factors contribute to the fatality?

[5] CFSA placed the Child Fatality Review (CFR) unit under the auspices of the Quality Improvement Administration (QIA) in FY04, at which time QIA developed a database to begin tracking and monitoring the number of decedents known to CFSA. In 2005, CFSA comprised a more accurate count of child fatality cases to be reviewed by its internal child fatality review process, and discovered a number of cases that were in a backlog status (no CFR in over 45 days).

- Providing pre-service and in-service training to CFSA social workers in how to respond to child fatalities and the child fatality review process.

Sources of Information

To prepare this report, the CFSA Child Fatality Review Unit analyzed information from the following sources:

- District of Columbia Chief Medical Examiner, CFRC, Metropolitan Police Department (MPD), and CFSA. The Child Fatality Review Unit worked closely with CFRC staff to obtain valid cause and time of death information through autopsy reports from the Chief Medical Examiner and to reconcile statistical data on fatalities.

- Our own reports concerning 58 fatalities in 2006 of children known to CFSA during the past four years. We also maintain a database that includes basic information about fatalities of children with whom CFSA had contact, such as date and cause of death (if determined), circumstances surrounding the death, and pertinent demographics.

- MPD and *The Washington Post*. These sources, in combination with information from the CFRC, provided time of death for violent homicides.

Fatalities of Children Who Had Contact with CFSA

A total of 142 District children died in 2006. Of these, CFSA had contact with 58 (41%) within the four years before they died. While overall child deaths in the city decreased over the past three years, deaths of children with CFSA contact remained above a third of all child deaths—37% in 2004, 36% in 2005, and 41% in 2006 (Figure A).[6]

Figure A: Citywide Child Fatalities and Those with CFSA Contact

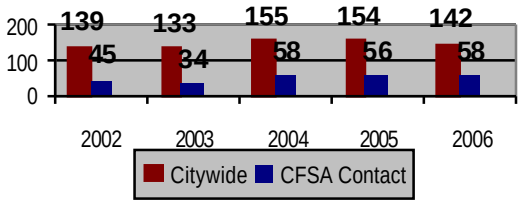


Table 1 shows cause of death and demographics for the 58 children who had contact with CFSA at any point from 2001 through 2006.

Table 1: Manner of Death and Demographics for 58 Children Who Died in 2006 and Who Had Contact with CFSA at any Point from 2001-2006

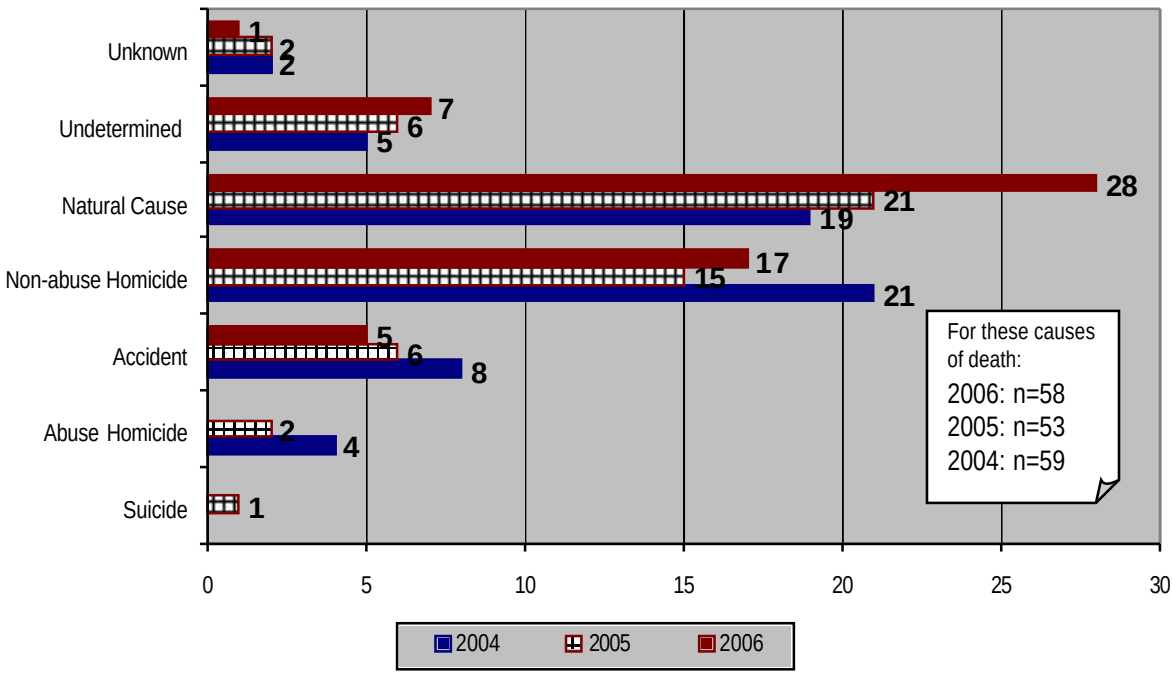
Manner of death*:	Natural Cause	Non-abuse Homicide	Accident	Abuse Homicide	Suicide	Not determined[7]	Pending[8]	Unknown[9]	Total
Age									
<24 months	18	0	0	0	0	7	0	0	**25**
2-6 years	0	0	1	0	0	0	0	1	**2**
7-12 years	1	0	3	0	0	0	0	0	**4**
13-16 years	6	2	0	0	0	0	0	0	**8**
17+ years	3	15	1	0	0	0	0	0	**19**
Gender									
Male	16	16	5	0	0	3	0	1	**41**
Female	12	1	0	0	0	4	0	0	**17**
Race									
African-American	28	17	5	0	0	7	0	1	**58**
Hispanic/Latino	0	0	0	0	0	0	0	0	**0**
Caucasian	0	0	0	0	0	0	0	0	**0**
Status with CFSA at Time of Death									
Closed case	7	5	2	0	0	1	0	0	**15**
Active case	10	0	1	0	0	2	0	1	**14**
Investigation (closed at Intake)	11	12	2	0	0	4	0	0	**29**
Placement Location at Time of Death									
Not applicable: case closed	10	12	2	0	0	4	0	1	**29**
In home	8	3	1	0	0	2	0	0	**14**
Foster home	10	2	2	0	0	1	0	0	**15**
Total	**28** (48%)	**17** (29%)	**5** (9%)	**0**	**0**	**7** (12%)	**0**	**1**(2%)	**58**

*Information from Medical Examiner or CFRC as of August31, 2007

[6] Final numbers provided by CFRC may differ from earlier reported numbers based on preliminary data.
[7] Medical Examiner issued an autopsy report but was unable to determine cause of death.
[8] Unavailability of cause of death or death certificate.
[9] Death occurred outside the District of Columbia. We could not obtain an autopsy report or death certificate.

Figure B provides a three-year comparison of seven causes of death for child decedents who had contact with CFSA within four years before they died.

Figure B: Three-Year Trend, Seven Causes of Death



Overall Findings

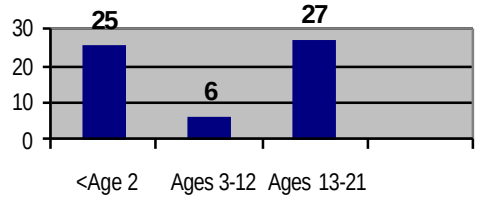
Following are major findings about the deaths in 2006, of the 58 District children and youth who had contact with CFSA at any time since 2001.

- **None of the children died from child abuse.**

- **For the second straight year, most of these children died of natural causes, followed by homicide as a leading cause of death.** In 2006, (48%) of the children died of natural causes, followed by gunshot homicide, which claimed 17 (29%).

- **Youngest and oldest children were most vulnerable.** Continuing a sad pattern in our city, 90% of these 58 children were either younger than age 2 or older than age 12 (Figure C). Leading cause of death for those under age 2 was natural (72%), while gunshot homicide was the leading cause of death for

Figure C: Age of Child and Youth Decedents, 2006



those over age 12 (63%). Thirty-three percent of those over age 12 died from natural causes.

- **Males were far more vulnerable:** More than twice as many male children died in 2006: 41 males (71%) compared to 17 females (29%) for a ratio of 2.4:1. Leading cause of death for younger males was natural. However, leading cause of death for older males was violent homicide (73%). In 2006, all five accidental deaths were males. Leading cause of death for females was natural (71%), followed by undetermined causes (24%).

- **CFSA had active cases with 14 victims or their families at the time of death.** Ten (71%) of these deaths were due to natural causes, one to an accident, two to undetermined causes, and one to an unknown cause. Of these 14 active cases:
  - Thirteen (93%) had single-mother heads of household.
  - Twelve (86%) had had five or more child abuse/neglect investigations.
  - Ten (71%) of the families were receiving public assistance.
  - Ten (71%) of the children were in foster care at the time of death.
  - Seven (50%) of the children had been born to teen mothers.
  - Six (43%) had fathers involved with the child and/or family.

- **Most of the children who died had one or more previous unfounded child abuse/neglect investigation.** At the time of death, CFSA had active cases with 14 children (24%) and closed cases with 15 (26%). Each of the remaining 29 children (50%) had been the subject of at least one unfounded report to CFSA's hotline. Because the investigation did not reveal child abuse or neglect, CFSA did not open a case with these children.

- **African-Americans were disproportionately represented in deaths of children with CFSA contact.** All of the children were African-American. At the end of 2006, CFSA's overall service population was 90% African-American. According to U.S. Census 2000, 60% of the District population is African-American.

In-Depth Analyses

The following sections take a closer look at specific circumstances related to the 58 children who died in 2006 by age group or cause of death.

Infant Fatalities

Children under age 2 had the highest number of fatalities of any single age category.

The highest number of fatalities of any single age category of children who had contact with CFSA occurred among those under two years of age (see Table 1). Table 2 provides an overview of these 25 children. All these infants were African-American. Thirteen (52%) were males, and 12 (48%) were females.

Table 2:
Fatalities of Children under 24 Months with CFSA Contact, 2006

Decedent	Age	Gender	Cause of Death	Case Status (at death)	Manner of Death
1	6 weeks	F	Complex Congenital Heart Disease	Closed	Natural
2	1 day	M	Prematurity	Prior report	Natural
3	23 days	F	Undetermined	Active	Undetermined
4	4 months	F	Sudden Infant Death Syndrome	Active	Undetermined
5	4 hours	M	Prematurity	Active	Natural
6	2 months	M	Sudden Unexplained Death in Infancy	Prior report	Undetermined
7	3 weeks	F	Multiple Congenital Birth Defects	Active	Natural
8	Died at birth	M	Immediate Cardiopulmonary Failure	Active	Natural
9	Died at birth	M	Premature Rupture of the Membrane	Closed	Natural
10	7 months	M	Asthma	Active	Natural
11	1 day	F	Prematurity	Prior report	Natural
12	9 months	M	Cardiopulmonary Arrest	Closed	Natural
13	5 weeks	F	Lung & Gastro Intestinal Hemorrhage	Prior report	Natural
14	1 year	M	Respiratory Arrest	Closed	Natural
15	5 months	M	Sudden Unexplained Death in Infancy	Closed	Undetermined
16	3 months	F	Undetermined	Prior report	Undetermined
17	3 months	F	Brain Damage and Cardiac Arrest	Active	Natural
18	Died at birth	M	Prematurity	Closed	Natural
19	Died at birth	F	Prematurity	Prior report	Natural
20	4 months	M	Undetermined	Closed	Undetermined
21	9 days	F	Undetermined	Active	Undetermined
22	1 day	M	Respiratory Distress Syndrome	Closed	Natural
23	1 day	M	Respiratory Failure	Closed	Natural
24	Died at birth	F	Prematurity	Closed	Natural
25	Died at birth	F	Prematurity	Closed	Natural

Decedents ranged in age from 0 (died at birth) to 24 months. As the table shows:

- Eighteen infants (72%) died of natural causes. The Medical Examiner could not determine the cause of death for seven (28%).

- Families of eight infants (36%) had active cases with CFSA at the time of death, and families of 11 (44%) had closed cases. CFSA received at least one report on six (24%) of the infant's families before the child died.

Fatality review reports for 22 of these infants further indicated that:

- Twelve mothers were age 18 or younger at the time of their first pregnancy resulting in a birth.
- Eight infants were born prematurely.
- Four mothers reported using substances including tobacco, alcohol, marijuana, and/or cocaine during pregnancy.
- Three mothers reported being in foster care as a juvenile.

Two infants were co-sleeping with a parent at the time of death. The manner of death for one of these infants was natural, and the manner of death for the second was undetermined.

Medically Fragile Youth

In 2006, 9 youth ages 13 and older died from natural causes. This high number compared to the previous two years served to increase the overall percentage of child decedents known to CFSA among all District children who died in 2006.

A high number of youth died from natural causes: 9 (16%) in 2006 compared to three (6%) in 2005 and six (10%) in 2004.

- Eight of these 9 youth decedents (89%) had received long-term medical care.

- Seven (78%) had histories of illness and were medically fragile. Three of the seven (43%) suffered from respiratory problems. Cause of death for the remaining four included pneumonia, heart disease, cancer, and brain infection. All seven were in out-of-home care at the time of death.

- Three (33%) were in the care of one or both parents at the time of death.

Homicides

Violent homicide continues to claim the lives of far too many District children and youth. Of the 36 District children who died as the result of homicide in 2006, CFSA had contact with 17 (47%) at some point from 2001 through 2006. All these homicides resulted from violence other than child abuse as defined by law.

For the third straight year, violent homicide was the leading cause of death for male youth known to CFSA.

The percentage of violent homicide deaths of youth known to CFSA in 2005 and 2006 remain at 47%. All the 2006 homicides resulted from gunshots and involved African-American youth ages 14 to 22. Victims included 16 males (94%) and one female.

CFSA had contact with five of the homicide victims within a year of their deaths. Persistent themes in the five tragic profiles below include:

- A high number of abuse/neglect reports—a total of 49 involved the families of these five victims.

- Youth who had experienced physical abuse, sexual abuse, and/or neglect and who had Attention Deficit/Hyperactivity Disorder (AD/HD) and/or behavioral issues.

- Long-running child welfare cases and youth who grew up in the local system during years when resources and case practice were far below par.

- Failure to provide or to engage the child/youth in effective services (lack of early and continuing intervention).

- Multiple, unstable placements, frequently including residential treatment.

- Criminal behavior and involvement of the youth in the juvenile justice system.

Homicide Victim #1: District child welfare[10] received five neglect and two abuse reports on behalf of the decedent and his siblings. District child welfare opened a case in 1985, and CFSA closed it in 2003. Child welfare investigators first observed the decedent at age 7. They assessed him as hyperactive, angry, disobedient, and neglected in terms of his emotional needs. This child had a professional diagnosis of AD/HD and received special education and counseling. At age 16, the decedent went to jail for stealing a car. He got out on his 18th birthday. He was shot less than a month later.

Homicide Victim #2: District child welfare received 12 reports of neglect and one of endangerment on behalf of the decedent and his siblings. District child welfare opened a case in 1994, and CFSA closed it in 2005. The decedent reported suffering sexual and physical abuse on more than one occasion. He had an extensive criminal record that included destruction of property and assault in a threatening manner. Staff of a residential treatment facility where the decedent lived for a time reported that he had a drug problem and was caught smoking marijuana in the facility. While there, he constantly absconded and refused to comply with rules. As a means of transitioning from the residential facility, CFSA referred him to a Healthy Families/Thriving Communities Collaborative for assistance in locating housing. The Collaborative paid his security deposit and first month's rent. CFSA closed his case the month before his 21st birthday. The decedent was shot one year after CFSA closed his case.

Homicide Victim #3: The family had 13 reports of physical abuse, neglect, and sexual abuse on behalf of the decedent and his siblings. The decedent first entered the child welfare system at age 1. He had experienced physical abuse at a very early age. Growing up in out-of-home care, he had numerous placements with several relatives and in foster care and residential treatment. His criminal record included one charge of assault with a deadly weapon and two charges of sexual abuse, the second of which he received at age 18. CFSA closed his case the following year. One year following his emancipation, this youth was shot several times.

Homicide Victim #4: The family had 11 reports of neglect on behalf of the decedent and his siblings. Their mother had been involved with the child welfare system beginning in 1978, during her own childhood. She grew up in several group homes, foster homes, and residential treatment facilities. The decedent spent the majority of his formative years in a shelter with his mother and sister and in the care of his grandmother. As the decedent got older, he showed frequent signs of adverse behavior. He was diagnosed with Adjustment Disorder with Disturbance of Conduct and also tested positive for PCP and marijuana. He frequently ran away from his placements and had a criminal record. Before CFSA closed his case, he had obtained full-time employment and was about to become a father. The social worker provided him with a voucher to purchase a few pieces of furniture before the baby arrived. CFSA closed this youth's case because he had stable housing and employment. He was shot multiple times the following year.

[10] The District established CFSA as a cabinet-level agency and began aggressive child welfare reform in 2001. Previously, the city's child welfare program was located in the DC Department of Human Services (DHS).

Homicide Victim #5: The family had five reports of neglect on behalf of the decedent and his siblings. District child welfare supported only one of these reports. The decedent had a diagnosis of AD/HD. He was hospitalized on five different occasions for homicidal thoughts, fighting, and destruction of property. He received special education services and grief counseling to help him cope with the death of his father. The decedent frequently absconded from residential treatment and had a juvenile record. He was shot four times. At the time of his death, he was enrolled in school and living with his grandmother.

Accidents

In 2006, five African-American males known to CFSA were victims of fatal accidents. One victim was age 4, two were age 7, one was age 11, and one was age 19. At the time of their deaths, one decedent was in District foster care, and one was living with a relative in the District at the behest of another state. One was living with a parent, one with a caretaker, and one on his own after leaving the child welfare system.

Three of the five accidental deaths in 2006 resulted from vehicles striking children.

While all these fatalities were truly accidental, one prompted CFSA to tighten procedures regarding transportation of children. While not directly related to the fatality, another situation led to improvements in administering the Interstate Compact on Placement of Children (ICPC). Details of these responses appear in the final section of this report, "2006 Recommendations and Actions."

Accident Victim #1, January 2006: A male child was a committed ward of Maryland. In October 2002, Prince George's County Department of Social Services (PGDSS) made an ICPC request for the District to place this child with his paternal aunt who supposedly lived in Southeast. The ICPC required CFSA to conduct a study of the aunt's home to ensure the placement was not contrary to the interests of the child and met all Federal and District foster home standards.

During this process, CFSA discovered that the decedent had already been living with his aunt for a year and that she had moved in with a relative. At this new location, she was sharing a bedroom with her son, age 5, and the deceased. CFSA advised the aunt that we could not approve these sleeping arrangements and that she should inform her social worker at PGDSS of her current situation. The aunt subsequently decided to halt the licensing process until her living situation improved. CFSA notified Maryland of the results of the home study, that we intended to close this ICPC case in the District, and that PGDSS should return the child to Maryland.

Issue:
CFSA followed ICPC procedures regarding a request for placement of an out-of-state child in the District but did not follow up with the sending jurisdiction upon discovering irregularities in their management of the case.

In January 2006, the District's Citywide Fatality Review Coordinator notified CFSA of this child's death at age 7. He and his mother got off a bus in the District, where a car struck both of them on South Capital Street. The child died on site. His mother died in a hospital two days later. The District's Medical Examiner ruled both deaths accidental.

After the fatality, CFSA contacted the PGDSS social worker and learned that the birth mother had consented to give the paternal aunt legal custody of the deceased. Mother and the aunt made this arrangement. The birth mother was to have weekend visits with her son. Both the Maryland court and PGDSS had closed their cases with this mother and child.

Accident Victim #2, February 2006: District child welfare removed this male, then age 12, and his three siblings from the home of their grandmother in 1998. CFSA closed his case in August 2005. At the time of case closure at the youth's request to Family Court, he had been in abscondance from the child welfare system since December 2004. However, he continued to have an open case with the juvenile justice system resulting from theft and unauthorized use of a vehicle in 2002. The court had also issued an adult bench warrant for his arrest due to drug charges.

In February 2006, police were pursuing this young man, age 19, because he had stolen a vehicle. They followed him to his girlfriend's apartment in a high-rise building. When questioned, the girl denied he was there. As the officers left the building, they saw the young man fall from an open window to his death. Reportedly, after police left the apartment, the young man and his girlfriend had a verbal altercation. She stated he lost his balance and fell out the open window. Police suspected but could not prove foul play. The Medical Examiner ruled this death accidental.

Accident Victim #3, April 2006: CFSA had received four reports about the family and determined all were unfounded. In April 2006, the three children, ages 4, 8, and 15, were walking home from a Boys and Girls Club between 8:15 p.m. and 8:59 p.m. They had just left the oldest child's band practice and were one block from home when the accident occurred. A hit-and-run motorist struck the youngest child as he crossed the street. Upon arrival at the scene, EMS found the child unconscious. Children's National Medical Center pronounced him dead upon arrival.

Accident Victim # 4, April 2006: District child welfare had a long history with some members of this family but no contact with the decedent. The decedent's troubled birth mother had been in foster care and the juvenile justice system. She had her first child at age 13 and relinquished him for adoption. In 1992, DC Superior Court terminated maternal and paternal rights for her second child. District child welfare had no further contact with Mother. However, her second child's case remained open with CFSA until he aged out of foster care in October 2004. This involvement with a sibling within four years of Accident Victim #4's death prompted CFSA review of this fatality.

After 1992, Mother gave birth to two more children, the younger being the decedent. Two weeks after the birth of the decedent, Mother gave him to a friend, who was still caring for him at the time of his death at age 7. CFSA has no record of any child abuse/neglect reports about Mother's two younger children.

In April 2006, the child was at a playground behind his apartment complex. He was chewing on a toy that made a whistling sound when a piece broke off and lodged in his throat. EMS arrived but could not dislodge the toy. EMS took the child to Children's National Medical Center, where

doctors retrieved the object from his throat. However, the hospital pronounced the child brain dead three days after the incident. An autopsy determined the manner of death was asphyxia due to choking. MPD notified CFSA of this fatality three days after the child died.

Accident Victim #5, July 2006: In August 1995, District child welfare removed the decedent and his sibling from their mother to kinship care. The decedent resided with kin until June 1997, entered foster care in October 1999, and was permanently committed to District child welfare custody in May 2000.

He had a history of social and emotional issues, including diagnoses of Conduct Disorder, Adjustment Disorder, Depressive Disorder, Defiant Disorder, and AD/HD. He had several evaluations and three hospitalizations. Experts recommended a classification of Multiple Disabled, including both a learning disability and emotional disturbance.

Evaluations reported that the decedent lacked "the internal coping resources necessary to manage a chronic state of stimulus overload." He was "vulnerable to becoming easily overwhelmed and at risk for impulsive behavioral acting out as well as irritable and sad-affect states." Experts recommended individual and group therapy weekly to deal with issues of low self-esteem, abandonment, loss, and abuse. They also recommended strict behavioral management plans for this child at home and at school, bi-weekly medication management by a psychiatrist, an older male mentor, therapeutic foster care, visits with his birth parents in the context of family psychotherapy, enrollment in a highly structured special education school that presented material verbally and in small quantities at one time, and one-on-one tutoring. District child welfare/CFSA coordinated services that fulfilled all these recommendations, although records do not clarify whether his birth mother ever participated in family therapy.

The decedent lived in six therapeutic foster homes from September 2000 until his death in 2006. He wanted to be with his family. He had been placed with a sibling; however, they had a very competitive relationship. A bonding study in August 2004, recommended separating these children.

The decedent had been the subject of a "Wednesday's Child" segment, in which local WRC-TV features adoptable children weekly during the news. As a result, CFSA found a pre-adoptive placement for him. This child had begun visits with the pre-adoptive family.

Issues:

- The medical transportation vehicle routinely carrying children involved with CFSA did not have child safety locks.
- The driver was the only adult in the vehicle with an excitable child known to need extensive supervision.

In July 2006,a medical transportation contractor drove this child, now age 11, and another child to their therapy sessions. The contractor had regularly transported this child to his sessions for some time. Impulsively, the child got out of the vehicle when the driver pulled to a stop across the street from their destination and ran around the vehicle to cross the street. A car immediately struck and severely injured him. EMS transported the injured child to Children's National Medical Center. Doctors determined the child had no brain function, and his birth family decided the hospital should remove life support.

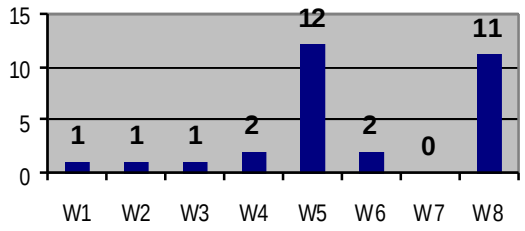
Geographic Location of Fatalities

Of the 58 children with previous CFSA contact who died in 2006, and for whom CFSA knows the location of the death, Wards 5 and 8 had the highest number of fatalities: 12 in Ward 5 and 11 in Ward 8.

Non-Homicide Child Deaths in the District

Three non-homicide child deaths occurred in Maryland. CFSA does not have location information for eight of the remaining 38 non-homicide deaths in the District. Figure D shows by ward, the location of death for the remaining 30 children who died in the District from a cause other than homicide. 23 (77%) died in Wards 5 and 8.

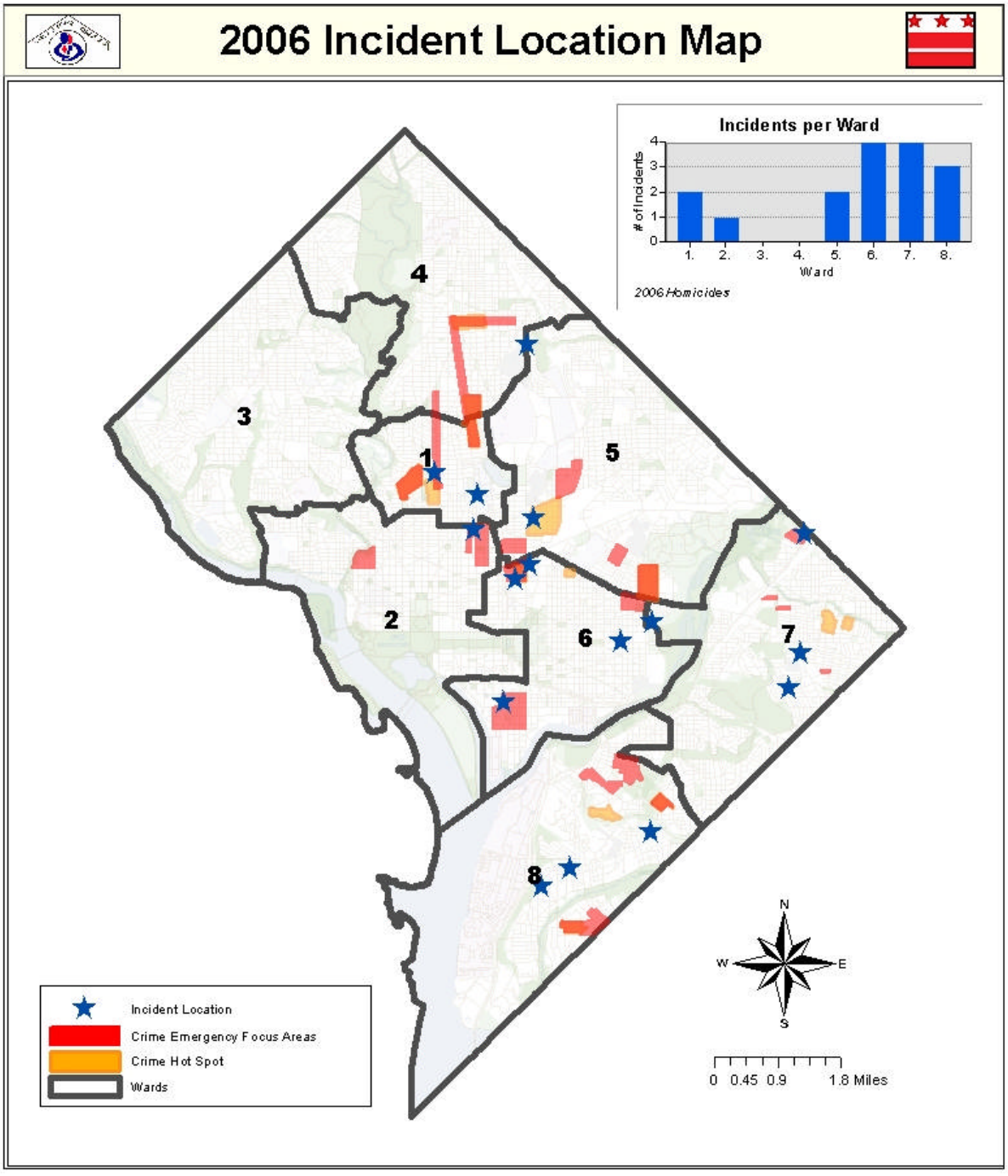
Figure D: Non-Homicide Death Location by District Ward for 30 Children with CFSA Contact



Child Homicides in the District

Figure E shows the location for 16 of the 17 homicides in 2006 of District children who had contact with CFSA at any time from 2001 through 2006. Eleven of the homicides (69%) took place in Wards 6, 7, and 8. Nine (56%) took place near locations the District has identified as crime hot spots or crime emergency focus areas.

Figure E: Location of 16 Child Homicides, 2006



2006 Recommendations and Actions

In 2006, the CFSA Internal Child Fatality Review Committee reviewed a total of 69 child fatality cases (58 from 2006 and 11 from the 2005 backlog) and made recommendations in the areas of Case Practice, Training, Policy, and Overall System. The Child Fatality Review Unit analyzed recommendations and identified themes indicating where CFSA needs to focus more attention. Themes we identified in 2006 largely echoed those from 2005. The Citywide Child Fatality Review Committee also identified similar issues. This section lists recommendations and reports CFSA progress in responding to a sample of them.

Selected Recommendations from the Citywide Child Fatality Review Committee

Resource Development

Recommendation: **The Deputy Mayor for Children, Youth, Families and Elders, in collaboration with CFSA, DMH, and other appropriate family- and child-serving agencies, should devise a plan to immediately resolve the problem of lost or inaccessible records with established times for implementation.**

Response: FACES, the CFSA Federally-approved State wide Automated Child Welfare Information System (SACWIS), has maintained soft case records since 1999. In April 2006, CFSA re-established a centralized filing system under the Records Management Unit (RMU). The RMU is improving storage and retrieval of CFSA hardcopy case records by:

- Creating a CFSA Record Retention Schedule (RRS) which is currently at the DC Records Center for approval.
- Drafting an administrative issuance governing transfer, storage/ maintenance, and archiving of CFSA case records. It is pending approval from the General Counsel.
- Inventorying all CFSA case records (active and closed), including those located at private agencies and archived at the DC and National Records Centers. The RMU is working with the Records Manager of the District of Columbia to devise an orderly process for inventorying records stored at the DC and National Records Centers.
- Developing a CFSA Records Management Policy Manual that will govern organization, management, transfer, archiving, and control of active and closed child welfare case records at both CFSA and private agencies.

Policy and Practice Standards

Recommendation: **DOH in collaboration with CFSA should develop clear policies, procedures, and monitoring protocols related to the provision of transportation through**

Medicaid to children committed to the District. CFSA should ensure that all contractors are aware of the policies/protocols and requirements for strict compliance. Protocols should minimally include:

- **Establishment of drop-off policy for drivers/escorts responsible for children, which includes escorting children to a supervised, secure location within the destination facility;**

- **Requirement that no child under age 18 (or older persons with significant disabilities) should be transported without an attendant (escort). As a check and balance, both the Medicaid transport vendor and CFSA (and its contractors) should arrange for an escort before transport;**

- **Requirement that all transport drivers comply with District laws related to child and vehicle safety (car seats, seat belts, etc.) and that all children are required to ride in the back of the vehicle; and**

- **Requirement that children with emotional/psychiatric illness, despite their ages, use seat belts and window/door (child) safety locks.**

CFSA in collaboration with contractors should conduct thorough investigations/critical event reviews (as required) of circumstances leading to the death of all children in its care/supervision, regardless of manner of death.

Response: CFSA expects constant supervision and monitoring of all children involved in the child welfare system. We expect social workers, foster parents, social services assistants, and/or other appropriate adults to transport and escort children to medical and mental health appointments. CFSA's Office of Policy, Planning & Program Support (OPPPS) is reviewing policies and procedures to ensure these criteria are clear to both CFSA and private agencies with case management responsibilities.

The private agency managing the case of the 11-year-old accident victim discontinued using Medicaid transportation services from the contractor who had transported the child. Further, the private agency amended its policies and procedures to require persons transporting children to:

- Pick up and drop off on the same side of the street as the destination and to park legally while picking up and dropping off clients.
- Accompany children into buildings and sign them in, if necessary.

CFSA has an internal child fatality review process that reviews all fatalities of children known to us within four years of the death. We also hold a critical event meeting within 24 hours of receiving notification of a child death. When applicable, private provider agencies participate in both the internal review and critical event meetings. Some private providers have their own internal child fatality review processes that allow them to review case practice, policy, training needs, and system issues.

Resource Expansion

Recommendation: **CFSA should examine therapeutic resources and supports offered to children in therapeutic placements and strengthen existing Therapeutic Foster Home services and Therapeutic Foster Parent training as needed.**

Response: In the past year, CFSA has issued contracts for new services to meet therapeutic needs. Among these are: Multidimensional Treatment Foster Care (MTFC), a therapeutic model to meet the needs of high-risk youth; expanded placement options for medically fragile children; developmental disabilities services; a Teen Bridge Program to prepare high-risk youth for independent living; and Star Homes to provide emergency services when a child has specialized needs that a traditional foster home cannot meet.

To strengthen existing therapeutic foster homes, CFSA's Monitoring Division is currently reviewing licensing requirements for therapeutic foster parents to ensure they receive adequate pre-service and in-service training. When Monitors discover a specific foster parent is lacking proper skills to meet the needs of the child in care, they notify the responsible agency to require the foster parent to attain additional training. CFSA can initiate contract action in the event the responsible agency fails to follow through on the request. CFSA is moving toward performance-based contracting and monitoring, which will hold therapeutic agencies accountable for achieving specific positive outcomes for children.

Multiple additional resources are available to foster parents including Intensive Home/Community-Based Services (IHCBS), the Mobile Urgent Stabilization Team (MUST), and core service agencies (CSAs). IHCBS provides intensive crisis management and stabilization, parent support, behavior management, and case management. MUST provides 24-hour crisis intervention in the home and links children to CSAs for mental health treatment, medication management, and community-based intervention.

Compliance with Existing Policies, Regulations, and Laws

Recommendation: **CFSA should follow and/or strengthen Interstate Compact policies and practices to ensure mechanisms that require:**

- **Follow-up contact with sending states to ensure they are aware of an Interstate Compact request being disapproved when the home does not meet District requirements; and**
- **The sending state immediately removes children placed in the District of Columbia prior to Interstate Compact approval.**

Response: CFSA's Interstate Compact for the Placement of Children (ICPC) Home Study Unit has a policy of completing home studies in the District for other requesting jurisdictions within 120 days. We then notify the requesting state of findings and recommendations within three to five business days. When we deny placement of an out-of-state child in the District, the ICPC Office now monitors and tracks those cases until all issues are resolved and/or the sending state removes the child/ren. The office keeps these ICPC cases open and communicates regularly with sending jurisdictions, including working with them to develop a resolution plan with benchmarks and an actual date of removal. The District of Columbia and Maryland Interstate Compact

Offices have also strengthened their working relationship and communication to work through issues regarding denial/disapproval of placements in both jurisdictions.

Selected Recommendations Regarding Policy and Practice Standards from the CFSA Internal Child Fatality Review Committee

Recommendation: **CFSA should explore the possibility of making referrals regarding pregnant preteens and teens a high priority and closely monitor these.**

Response: Recognizing the many risks associated with children having children, pregnancy among teens and preteens has a high priority with CFSA's Office of Youth Development (OYD). OYD assigns experienced social workers to pregnant and parenting teens and preteens, and these social workers routinely coordinate referrals to DC Healthy Start, Healthy Babies, Teen Alliance for Prepared Parenting (TAPP), and Unity Neighborhood Health Clinics.

OYD has partnered with the DC Campaign to Prevent Teen Pregnancy in providing training and developing protocols for encouraging teen pregnancy prevention. CFSA is exploring replication of a teen pregnancy prevention program that has been successful in New York, and a CFSA-led task force is working on a citywide response to this issue. In 2006, OYD partnered with the DC Department of Parks and Recreation and DC Campaign to Prevent Teen Pregnancy to establish an annual four-hour "Teen Pregnancy Prevention Summit" for teens. This event attracted hundreds of participants in both 2006 and 2007.

Recommendation: **Social workers should provide high-risk families with information regarding SIDS, safe sleeping methods, and family planning.**

Response: CFSA uses the DC Department of Health's Maternal and Family Health Administration to train families regarding Sudden Infant Death Syndrome (SIDS), Sudden Unexplained Death in Infancy (SUDI), safe sleeping methods, and family planning. Social workers access this service through CFSA's Office of Clinical Practice for any and all families who would benefit. Availability of these services was the topic of a CFSA Program Operations all-staff meeting in September 2006.

Recommendation: **The Collaborative Liaison Manager should continue to monitor and serve as gatekeeper for all referrals to the neighborhood Collaboratives.**

Response: In November 2005, CFSA established and filled the position of Liaison Manager to the Healthy Families/Thriving Communities Collaboratives. Since then, the Liaison Manager has been instrumental in improving the CFSA-Collaborative partnership and CFSA referral of families for services from the Collaboratives. The Liaison Manager established and maintains a database that tracks all CFSA referrals to the Collaboratives, increasing CFSA knowledge of

referral volume and ability to hold the Collaboratives accountable for responses. The Collaborative Liaison's Social Services Assistant (SSA) coordinates referral staffings between CFSA Child Protective Services (CPS) social workers/supervisors and the Collaboratives. After gathering information from the CPS social worker, the SSA meets with the Collaborative Intake Supervisor, provides updates on referrals three times a week, and keeps records and tracks Collaborative date of receipt and acceptance.

Recommendation: **CFSA (Program Monitoring) should ensure contracted agencies have a comprehensive internal review of deaths immediately after a death occurs. Contract agencies should then submit a written report to the CFSA Child Fatality Review Unit.**

Response: When a child dies on a case for which a private agency has case management responsibility, that agency must immediately contact the CFSA hotline and send an Unusual Incident report to the CFSA Program Monitor. The private agency must also attend a Critical Event meeting at CFSA to discuss the fatality and develop immediate next steps in the case. One recommendation is that the private agency should hold an internal review and forward a written report to CFSA. Private agencies are aware they must attend CFSA Internal Review meetings regarding any children on their caseload.

Recommendation: **It should be standard practice to fully investigate all allegations of sexual and physical abuse and to medically screen all alleged child victims.**

Response: Before 2002, the District had a bifurcated system in which police investigated all reports of child abuse and District child welfare investigated allegations of child neglect only. Since 2002, CFSA Child Protective Services (CPS) has investigated all allegations of abuse, involving police whenever an allegation may rise to the level of criminal activity. The CPS Administrator and Director of the Child and Adolescent Protection Center at Children's National Medical Center (CNMC) discussed the need for a protocol and determined that not all cases involving allegations of sexual and physical abuse require medical screening. CPS social workers must use their clinical judgment and document visible injuries. When they have concerns about physical or sexual abuse with no visible injuries, CPS social workers schedule a medical evaluation to rule abuse in or out. CNMC Child Protective Services performs sexual abuse screenings, and CNMC medico-legal performs physical abuse screenings.

Recommendation: **Systematically evaluate how well the Memorandum of Understanding (MOU) between CFSA and MRDDA is working**.

Response: In October 2006, CFSA Office of Clinical Practice (OCP) hired a Special Needs Liaison (SNL) as required by the MOU between CFSA and the District Department of Disability Services [(DDS)—formerly the Mental Retardation/Developmental Disabilities Administration (MRDDA)]. The SNL at CFSA is responsible for:

- Developing and maintaining a database of children with special needs, physical and developmental disabilities, and mental retardation. Because CFSA needs to track the scope of needs within the foster care population, "special needs" is loosely defined to include all children with any developmental, cognitive, and/or physical impairment and children of normal development who require long-term medication/treatment for a chronic medical illness or medical condition that, if left untreated, may lead to serious illness.

- Providing consultation and support, in collaboration with the Heath Services nurses, to social workers regarding the needs of affected children, youth, and caregivers and assisting with coordination of resources.

- Working with DDS, social workers, youth, and caregivers to ensure a smooth transition and quality services for youth moving from CFSA to DDS.

- Serving as the referral center and resource for social workers submitting application packets to DDS. The SNL and DDS Intake Supervisor confer at least biweekly regarding CFSA cases. The CFSA Medical Director, Health Services Program Manager, SNL, DDS Intake Supervisor, and DDS Chief Operating Officer meet monthly to discuss systemic or complex issues or concerns generated over the previous month related to transition of youth.

This process has resulted in significant improvement in planning and preparation for youth who leave CFSA and move to DDS for supportive services, thus meeting requirements of the MOU.

Recommendation: **Review and clarify policies regarding investigation of alleged maltreaters of children involved with CFSA but residing outside the District.**

When investigations cross jurisdictions, CFSA should make telephone contact with the respective jurisdiction and follow up with a letter to ensure a paper trail. Any contact or communication should be clearly documented.

Response: CFSA policy requires that when an investigative social worker determines that CFSA children residing outside the District have been maltreated in that jurisdiction, the CFSA investigative worker must conduct part of the investigation without violating judiciary boundaries by interviewing parties at CFSA or CNMC. The investigating worker then requests a courtesy interview and home visit from the outside jurisdiction and documents letters, telephone contacts, and results from the other jurisdiction in FACES. The CPS unit supervisor monitors compliance when approving closure of an investigation. The investigative worker may also consult with an Assistant Attorney General, if necessary.

Recommendation: **The General Counsel should advise CFSA in writing on the legal responsibility of the Agency to report a client having a child abuse history with CFSA when the client works with children.**

Response: By law, employers must request information, with the signed, notarized consent of the job candidate or employee, before CFSA can screen the person through the Child Protection Registry and report findings. ¡